



<http://health.mo.gov/seniors/nursinghomes/providerinfo.php>

Through the Times...

By Barbara Primm

Some time back, I interviewed Loch Haven Assistant Administrator Barbara Primm for the purpose of writing a blog article about her home's culture change journey. As we spoke, I began to realize that her knowledge and experience were extraordinary. I didn't feel that the typical interview and blog article would be sufficient, so I asked if she would be willing to write a series of short articles chronicling Loch Haven's history and journey. Barb agreed and this is where her story begins.

I am Barbara Primm. Some of you may know me. Some of you may have heard of me...seen my name as one of the developers of the CNA or CMT manuals... heard me speak at some seminar... know that I am part of the team for the University of Missouri Sinclair School of Nursing's Leadership Academy for Long-Term Care Nurses... know that I have been associated with Loch Haven Senior Living Community in Macon for more than 40 years. But many of you, probably most, have never heard of me.

Although I am now jokingly "semi-retired," I am still very passionate about continuing to push for the best in long-term care and senior living. In the next few months I would like to share some of the history I have lived and some memorable experiences of my 48-year career in long-term care. This idea came from Sam Plaster, our state culture change director. I think Sam recognized that I am one of the living dinosaurs of long-term care in Missouri and sharing memories makes all of us, young and old, stronger. We in Missouri are so fortunate to have the support of regulators like Sam as we continue on this culture change journey. His commitment and passion are an example for us all.

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Where to begin? Well, two years ago we opened skilled nursing cottages here at Loch Haven Senior Living Community in Macon. They are so dramatically different from their ancestors that it seems they could have been dropped by advanced civilization aliens. Yet the feeling is wonderfully welcoming and cozy for the 12 residents living in each cottage. These cottages are compelling evidence of how the culture has changed in long-term care.



(1905 photo) Lakeview Nursing Home, above, was first known as the Macon County Infirmary, according to the Macon County Missouri Photographic History, Volume Two. It replaced the "poorhouse" or poor farm located just north of Macon. By the time I arrived at Lakeview as a 22- -year-old nurse in 1967, it had fallen into disrepair from 60-plus years of hard use.

1967

My mind flashes back to my first encounter with a "nursing home" here in Macon. It was 1967. I had just resigned my position as a psychiatric nurse to be a full-time mom to our month-old son.

The "nursing home" or county home was Lakeview. It was often known in the community as the "poor farm" or "poor house." Most counties in Missouri had something similar to Lakeview.. County homes developed out of community attempts to care for the poor and disabled and often included a lot of elderly folks.

Geraldine March, a licensed practical nurse, managed Lakeview. She called one afternoon and asked (maybe she begged) if I would be a registered-nurse consultant for the county home, emphasizing it would involve only four hours a week. I had never liked geriatric nursing in college so I declined. A few weeks went by. My son was fussy on the afternoon she called again. I thought getting away for four hours a week might be a good thing. And so it began.

The building was deplorable. Two story. No elevator. Crumbling brick walls. When it rained, water came through the roof, but I was surprised to see it running down the side walls, too. However, the caregivers were kind local women and Mrs. March and her extended family were all involved in seeing that the 47 residents knew they were loved and had their basic physical needs met. I saw firsthand how much that care was needed and generally appreciated. Even though a resident tried to kick me the first day I walked in the front door, I was hooked after the first month!

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Before I knew it, I was attending regional meetings with Mrs. March. The focus was how to improve funding and care for our elders. I guess that was the beginning of my advocacy for long-term care. Many twists and turns have happened since those early days in the late 60s.

I began to wonder how this system of elder care came to be acceptable. In our community there were no other alternatives for elders who did not have family members to care for them at home. Rich or poor, they came to the county home— pitiful as the conditions were— when there was no one to care for them.

I discovered that in Missouri, as in most other states at that time, there were very few regulations pertaining to long-term care. A fire at Cedar Grove, an “old folk’s home” in Hillsboro, Mo., in 1952 resulted in the death of 20 residents. This link connects to an interesting article about the sad event. Link: <http://www3.gendisasters.com/missouri/1716/hillsboro,-mo-nursing-home-fire,-oct-1952>

This garnered some attention, but no major change in regulations.

Then in 1957 the Katie Jane Memorial Home in Warrenton, Mo., burned on a Sunday afternoon in February. The fire started during church services at the home and quickly tore through the aged two-story structure. Ultimately 72 residents died. This link tells the story: <http://www3.gendisasters.com/missouri/1087/warrenton-mo-nursing-home-fire-feb-1957?page=0,2>

Two major fatal fires had occurred in Missouri less than 75 miles apart and within five years. Apparently this is what it took to get action!

The Missouri Legislature met the day after the Warrenton fire and immediately introduced a bill to require sprinkler systems in all nursing homes and other state institutions. That bill did not pass, but some regulations did.

In 1963 the Missouri Legislature passed a bill allowing for the formation of nursing home districts in our state. More than 30 districts have been organized, and about half are in northeast Missouri.



Lakeview Nursing Home, circa late 1960's. *Courtesy of the Macon Chronicle-Herald.*

The Macon community was blessed to have a number of visionary folks who organized a nursing home district in the mid-60s. According to local newspaper accounts, it was quite a struggle to get the district established. Six local citizens were elected to serve on the board. The organizational structure resembled a school district; elected board members would hire an administrator to run any new nursing home.

However, there was a slight problem. Voters rejected several bond issues that would have funded a new nursing home. Finally, the issue did gain voter approval and construction began on a facility just a city block away from the old county home in the west hills of Macon.

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It was a proud day in late February of 1970 when we began the process of moving the 47 residents of the old county home into the 83-bed Loch Haven Nursing Home, operated by the Macon County Nursing Home District. It was shiny new. Everything worked! No broken pipes. No leaky roof. New windows kept rain, sleet and snow out of the building.

Over the years many have asked the origin of the name “Loch Haven.” The nursing home district held a naming contest, open to district residents. Katherine Hurlinger, who with her husband operated the very popular drive-in restaurant, the Frostop—famous for onion rings, burgers and fries—submitted the winning entry. From the hilltop on which Loch Haven was built, you can see Macon Lake, especially if the trees are bare. Loch is the Scottish name for lake. Katherine thought of the new home as a haven for the residents who moved from the old county home, as well as all the others who would need services in the future. In 2000, she became one of the residents at Loch Haven for her remaining years. She always took pride in being the one who named Loch Haven.

In my next article, I will share my experiences of the 70s and early 80s.

Someone You Should Know

Priscilla Farrall

Priscilla Farrall grew up in a small Connecticut town that owned undeveloped land next to her house.

“The land was the perfect playground for the neighborhood kids,” she said. “We had a creek to wade in and trees to climb. Boulders leaned against each other in certain ways that made for little caves to hide in when playing hide-and-seek.”

Ms. Farrall attended Notre Dame of Maryland University in Baltimore, the same college as her mother. Ms. Farrall’s college roommate was also the daughter of alumna, and remarkably the two still keep in touch.

Ms. Farrall’s best job was as a stay-at-home mom, raising two boys on five acres outside Tulsa, Oklahoma.

“We had a dog and a cat, a vegetable garden and a strawberry patch,” she said. “Bluebird boxes were along the fence line and wildflowers such as spring beauty and daisy fleabane grew everywhere.

Most of Ms. Farrall’s employment was at academic and city libraries. Before retiring, she worked for the Texas School for the Deaf, a pre-K to post-12 school, and was required to attend American Sign Language classes.

“In the beginning, I was very nervous and made a lot of mistakes when communicating with the deaf teachers,” she said. “They would get this certain smile that told me I was making a big and sometimes off-color mistake. As with any new endeavor, I just had to be brave and keep on signing,” she said.

She often watched two deaf people communicate, focusing on their hands and facial expressions, to see if she could pick out the signs she learned in class.



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Ms. Farrall and her husband at Cabot Trail Seaside

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"From watching these communications, I realized how validating and energizing it is for someone to receive another's undivided attention," she said. "To this day I try to bring into the hearing world this focused attention that is an integral part of the deaf world."

Ms. Farrall and her husband retired in Austin, Texas. But "Texas is a state with only two seasons – hot and not-so-hot," she said. They yearned for a state with four seasons, and Missouri fit the bill. After visiting Lenoir Woods in Columbia, the couple received a phone call about their preferred house becoming available. They immediately flew to Columbia to sign papers. They loved the house because it sits directly across the street from the woods.

Ms. Farrall volunteers to take care of the courtyard at Lenoir Woods Care Center. She first heard about MC5— the Missouri Coalition Celebrating Care Continuum Change (MC5) — through center Director Jill Layne, who recommended her as an MC5 elder advisor.

"Changing health care culture to person-directed approach is like turning an ocean liner around," Ms. Farrall says. "It's slow, hard work, and I'm in awe of the MC5 board members for their heartfelt dedication to this effort. Living at Lenoir, with its continuum of care, has helped me see how MC5, administration, staff and residents all fit together in this culture change endeavor."



*Ms. Farrall speaking at the
2015 MC5 Regional
Representative Training*

Undisturbed Sleep

By: Sam Plaster, State Culture Change Coordinator

Scientists seem to agree that we all need seven to eight hours of uninterrupted sleep nightly. Over time, poor sleeping habits have significant negative consequences. The elderly and individuals with dementia are far more likely to suffer from sleep disorders, which make it so important that long-term care environments and care practices are not compounding already significant problems.

I hear about residents' sleep being interrupted for numerous reasons. Their blood is drawn or vital signs are checked; they have incontinence care, are repositioned, take medications (including sleeping pills), get ready for breakfast; or, they are awakened because of alarms going off, carts being rolled down the hallway, supplies being restocked, shift change, or lights in the hallway. The list goes on and on. Most of these issues are caused by practices based on staff convenience and can be resolved with some simple changes. Others are a bit more complex.

State regulation 19 CSR 30-85.042 (70) currently requires that staff perform position changes every two hours for residents who are physically or mentally incapable of changing their own position. I've been told that two-hour repositioning and continence checks are the "accepted standard of practice."

Are two-hour repositioning and continence checks really the accepted standard of practice?

I found that older guidance is more likely to include two-hour repositioning and continence checks as the accepted standard of practice. More recent research and guidance call for a more individualized approach, especially in conjunction with the use of more modern pressure-relieving surfaces and incontinence products.

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I started by checking to see what federal surveyor guidance says. The guidance at F314 Pressure Sores, in Appendix PP of the Center for Medicare & Medicaid Services' State Operations Manual, requires individualized interventions and recognizes that standards of practice are evolving. Resources from the Agency for Healthcare Research and Quality (AHRQ), the National Pressure Ulcer Advisory Panel (NPUAP), the American Medical Directors Association (AMDA), the Quality Improvement Organizations (QIO), the Wound, Ostomy, and Continence Nurses Society (WOCN), and the American Geriatrics Society (AGS) are specifically referenced, so I sought out the latest guidance these organizations have published:

Agency for Healthcare Research and Quality:

The most recent guidelines found on the AHRQ website, <http://www.guideline.gov/content.aspx?id=43935#Section420>, say, "Repositioning schedules should be individualized based on the patient's condition, care goals, vulnerable skin areas, and type of support surface being used."

The National Pressure Ulcer Advisory Panel:

The "2014 Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline" describes an individualized approach to repositioning frequency that includes consideration of pressure redistribution support surface, tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort. The new guidelines are available for purchase at the NPUAP website. The Quick Reference Guide is free at <http://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf>.

The American Medical Directors Association:

The following statements are from the AMDA "Pressure Ulcers in Long-Term Care, Clinical Practice Guidelines":

- ♦ "Evidence does not support any specific time interval for turning patients as a preventative or healing strategy for pressure ulcers."
- ♦ "Repositioning schedules should be individualized according to a patient's needs, care goals, tissue tolerance, and response to treatment."
- ♦ "Patients at risk of skin breakdown should be placed on a static support surface (e.g., foam overlay, foam mattress, static flotation device) rather than a standard mattress."

And the following statements are from the AMDA "Sleep Disorders, Clinical Practice Guidelines":

- ♦ "It is recommended that medical directors and managers of long-term care facilities adopt policies and procedures that enhance residents' ability to obtain a good night's sleep."
- ♦ "Nighttime incontinence care should be individualized; the goals are to minimize sleep disruption, prevent skin problems in immobile patients, and prevent falls in patients with dementia. For example, implement a policy of 'checking and changing' patients after 10 p.m. only if they are awake. Avoid fluid intake (especially of caffeinated beverages) before bedtime and ensuring that patients are toileted before going to bed may help to reduce nighttime awakening due to nocturia."

These clinical practice guidelines are available for purchase at the AMDA website, www.amda.com.

The Quality Improvement Organizations:

The TMF Quality Innovation Network website includes an article entitled, "Less Frequent Turning is Needed with the Right Equipment and Practice, Pressure Ulcer Study Finds." The article cites recent research that compares repositioning at two-, three-, and four-hour intervals. The incidence of pressure ulcers is the same with all three groups. The article is available at http://www.mcknights.com/news/less-frequent-turning-is-needed-with-the-right-equipment-and-practices-pressure-ulcer-study-finds/article/319902/?DCMP=EMC-MCK_Daily.

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The Wound, Ostomy, and Continence Nurses Society:

I found two free webinars on the WOCN website, “Advancing Prevention Through Science: State of the Science in Pressure Ulcer Prevention,” presented by Nancy Bergstrom, Ph.D., RN, FAAN, and “Application of the Science of Pressure Ulcer Prevention in the Clinical Setting,” presented by Elizabeth A. Ayello, Ph.D., RN, ACNS-BC, CWON, MAPWCA, FAAN.

In the first webinar, Dr. Bergstrom discussed the Turning for Ulcer Reduction (TURN) study. The purpose of the TURN study was to determine the efficacy of three repositioning schedules, two-, three-, and four-hours. Dr. Bergstrom said the differences between two-, three-, and four-hour turning were not significant. “When we’re turning people every two hours, particularly at night, we’re awakening them, depriving them of sleep and perhaps decreasing the quality of life and their ability to recover and carry on.”

Dr. Avello also mentioned the TURN study and said, “We’re beginning to question what is the right time interval for turning and repositioning.”

The webinars are available at <http://www.wocn.org/news/news.asp?id=197959&hhSearchTerms=%22pressure+and+ulcer+and+prevention%22>.

The American Geriatrics Society:

I was unable to find specific guidelines published by the American Geriatrics Society; however the following statement is from the article, “Nighttime Sleep and Bed Mobility among Incontinent Nursing Home Residents,” published in the Journal of the American Geriatrics Society in 1993:

“The majority of incontinent nursing home residents self-initiate sufficiently frequent movements at both the shoulder and hip so as not to be in need of frequent repositioning by nursing staff. Since the sleep of many of these residents is also characterized by frequent awakenings, incontinent nursing home residents may benefit from a schedule of nursing care at night that considers sleep of equal importance to incontinence care and body repositioning.”

An abstract of the article is available at <http://www.ncbi.nlm.nih.gov/pubmed/8409175>.

In 2014, I sat in on a webinar on the Empira Fall Study. Empira is a collaboration of nursing homes in Minnesota involved in gerontological research, funded through the Minnesota Department of Human Services’ Performance-Based Incentive Payment Program.

Sixteen skilled nursing homes participated in a three-year investigation to identify the root causes of resident falls. During the project, the prevalence of falls was reduced by 31 percent through interventions that included noise reduction and alarm elimination.

Sleep disturbance was also identified as a primary factor that contributed to falls. However, it was determined that additional research was necessary. Funding was obtained and a second, three-year project was initiated, but we would have to wait for results.

The original webinar is still available through the Pioneer Network at <http://www.pioneernetwork.net/Events/OnDemand/>.

I recently had the opportunity to attend the 2015 Pioneer Network conference in Chicago. Empira team members Sarah Brown, RN, BS, LNHA; Sue Ann Guildermann, RN, BA, MA; and Cindy Morris, BS, MBA, LNHA, led an all-day intensive training session entitled, “Restorative Sleep Vitality Program,” and shared the results of the second, three-year study.

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I will share some points that I believe warrant serious consideration.

During the three-year project, Empira representatives gained exhaustive knowledge of sleep hygiene from existing evidence-based research. They also attended national and international sleep conferences and conventions. They learned that adult humans need an average of seven to eight hours of “uninterrupted” sleep nightly. Elders require an average of eight hours.

Ms. Guildermann shared that military-professional presenters at an international sleep conference said sleep fragmentation is the most effective method for breaking down enemies physically and psychologically. Two-hour disruptions are the most effective intervals.

Sleep occurs in cycles and each stage provides distinct physiological and emotional benefits. Those cycles aren't attained and the benefits aren't realized when sleep is fragmented by even slight interruptions. Individuals subjected to sleep fragmentation over long periods of time suffer significant harm. Symptoms of sleep fragmentation include:

- * Excessive tiredness during the day;
- * Decreased alertness;
- * Memory loss;
- * Disorganized and/or delusional thinking;
- * Problems with processing things seen and/or heard;
- * Increased irritability;
- * Disturbed mood and extremes of manic behavior;
- * Loss of emotional control e.g. anger management;
- * Increased behavioral expressions of discomfort; and
- * Loss of social appropriateness.



Ms. Guildermann pointed out that these symptoms are nearly identical to those of psychosis and questioned whether antipsychotics are sometimes being used to treat incorrectly diagnosed symptoms of psychosis that are actually brought on by sleep fragmentation.

During the Empira study, many interventions were put into place to reduce sleep interruptions, including the use of pressure relieving mattresses, improved incontinence products, and barrier ointment/creams.

Instances of incontinence were reduced through fluid monitoring and management. Residents were encouraged to drink lots of fluids in the mornings, but to taper fluid intake after lunch, and minimized as much as possible after dinner. Medication administration schedules were altered to minimize the need for additional fluids for evening medications. In instances when evening medications were necessary, liquid medications were used because fluid intake is less than what is necessary to take pills.

Residents wore wrist actigraphy devices to monitor movement. The devices suggest that many residents reposition themselves while sleeping, eliminating the need for staff to reposition them.

Skin condition assessments were conducted, allowing for longer and longer periods of not being repositioned, changing incontinence products, or toileting. Through these interventions and many more, the percentage of residents who were to receive two-hour checks and/or repositioning was reduced from 99 percent to 7 percent. Reducing interruptions resulted in no negative outcomes.

The two-hour repositioning frequency required by 19 CSR 30-85.042 (70) will be considered for revision when the regulation is open for review. In the meantime, surveyors expect person-directed, individualized care, and evidence-based approaches to assessment, care planning, and care delivery.

Getting Ready for Bed

By: Carol Siem, QIPMO Clinical Educator

“Sleep is the golden chain that ties health and our bodies together.” —Thomas Dekker

Sleep is necessary for our bodies to remain healthy. Without proper rest and the deep stages of sleep, we will not feel well and our bodies can't be at their best. Poor sleep is not a normal part of aging. As we get older, we often get less sleep because our ability to sleep for long periods in deep restful stages can decrease. Our sleep is more fragile and we are more easily disturbed by light, noise and pain. We also may have medical conditions that contribute to sleep problems.

Our bodies heal in deep sleep stages. Starting at the cell level, the cells repair themselves. Muscles, bones and joints heal and grow, and our skin and connective tissue regenerate. If our bodies are not allowed time to renew, how can we fight infections? Deep sleep is also when we decrease our stress and retain what we learned during the day.

The dream stage of sleep is just as important. It helps us with memory recall and also relieves stress. If we don't get a good night's rest and fail to dream, we may be more stressed and more easily confused the next day.

How do we get ready for bed? Most of us will brush our teeth, go to the bathroom one more time, and put on different clothes. How do our residents get ready for bed? They may complete the first two tasks, but what do they wear to sleep? Depending on the nursing home, they may wear their own pajamas or a hospital gown several sizes too big.

If our residents are not comfortable in their night clothes, how will they get a good night's sleep? What else do we do that may disturb their sleep? What about the “turn-every-two-hours-, and as-needed” practice? As noted in Sam Plaster's “Sleep Interruptions” article, that practice is not supported by research and it is not in the Appendix PP Guidelines for Surveyors. Once, restraints were touted as a “good” way to prevent falls, but nursing care has evolved. We now know restraints are harmful and that turning a resident every two hours may not be necessary.

How do we determine when a resident needs to be turned? The research is sparse on this issue. The Centers for Medicare & Medicaid Services' Guidelines for Surveyors provide a suggestion for homes to determine how long a person can lie in one position before there are signs of tissue injury. The procedure is labor intensive. It requires checking residents for skin redness or tissue injury at 30-minute intervals after they have lain in the same position for more than an hour and documenting the process. However, no published study has determined that procedure's validity or reliability in predicting pressure ulcer development. The “Comparison Study of Braden Scale and Time-to-Erythema Measures in Long-term Care” supports the use of a valid and reliable risk assessment to develop an individualized care plan to prevent pressure ulcer development. The article was published in the Journal of Wound, Ostomy and Continence Nursing and is available at <http://journals.lww.com/jwoconline/pages/articleviewer.aspx?year=2015&issue=09000&article=00005&type=abstract>.

“The Effectiveness of a Pressure Ulcer Intervention Program on the Prevalence of Hospital Acquired Pressure Ulcers: Controlled Before and After Study,” published in Applied Nursing Research, supports individualized turning schedules based on each individual's particular needs. An interdisciplinary team needs to look at the resident and their overall health and risk assessment to set a baseline of turning. The nursing staff should then observe the resident's skin for redness or tissue injury to see if turning needs to occur more often. If not, the resident should be allowed to sleep at longer intervals undisturbed. The article is available at [http://www.appliednursingresearch.org/article/S0897-1897\(14\)00112-8/fulltext](http://www.appliednursingresearch.org/article/S0897-1897(14)00112-8/fulltext).

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Incontinence may pose another challenge. Some may think, “I can’t allow someone to lie in a wet bed!” or, “Residents must not sleep with incontinence briefs because we need to let their skin breathe.” In fact, historically nursing homes required residents to sleep nude from the waist down to protect them from skin breakdown caused by moisture retention in their incontinence briefs. But we now know that sleeping without undergarments may be demeaning to some. What’s more, incontinence products have improved over the years. They have similar wicking properties as baby diapers, which keep moisture away from the skin. And as parents, we let our babies sleep in diapers; we didn’t change those diapers during the night unless our babies woke and cried. Good adult briefs have the capacity to hold adult size amounts of urine and keep the skin dry. Gone are the days of one-size-fits-all adult briefs. Residents respond to individualized care, so they also need individualized incontinence products to meet their specific needs.

Promoting a good night’s sleep will be a challenge for many of us. It means changing old habits and learning new ways to meet a resident’s individual needs.

“Sleep is the best meditation.” —Dalai Lama



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